

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division-Licensure Bureau

2401 Colonial Drive

P.O. Box 202953

Helena, MT 59620-2953

FAX: (406) 444-1742

Indicate type of services being licensed:

INPATIENT CHEMICAL DEPENDENCY FACILITY_____

INPATIENT FREE STANDING CHEMICAL DEPENDENCY FACILITY_____

Facility Name: _____

Facility Address: _____ PO Box: _____

City _____ Zip _____ County _____

Facility Telephone Number: _____ FAX: _____

Facility E-mail/Web page Address: _____

Floor Plan is: ☐ New Construction ☐ Existing Structure ☐ Addition ☐ Remodeled

Operating Organization: ☐ State ☐ Individual ☐ Partnership ☐ Church ☐ Corporation ☐ Association

Name of Applicant: _____

Applicant Address: _____

City _____ State/Zip _____

Applicant (or contact) e-mail address: _____

Administrator of Facility: _____

Owner (If different from Applicant): _____

Owner Address: _____ City _____ State/Zip _____

Indicate type of services to be provided (if Residential, also indicate proposed number of beds):

[] Detox No. Beds_____ [] Inpatient No. Beds_____ Total Inpatient Beds_____

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Information on ownership, contract, or lease agreement if operated by a person other than the owner:

- If a partnership, firm or association, list every member thereof.
- If a corporation, list the name and address thereof and the names of its officers.

NAME

ADDRESS

(Please attach additional sheets as needed.)

List name, type of profession and license number of all licensed professionals employed by your Facility:

NAME

LICENSE TYPE

LICENSE NO.

(Please attach additional sheets as needed.)

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Check the following if they are correct:

☐ The applicant or any person managing have never been convicted of a felony. Section 50-5-207 (c)

50-5-207 MCA. Denial, suspension, or revocation of health care facility license -- provisional license. (c) The applicant or any person managing it has been convicted of a felony and denial of a license on that basis is consistent with **37-1-203** or the applicant otherwise shows evidence of character traits inimical to the health and safety of patients or residents.

☐ The applicant and managing personnel have never been denied a license. (Section 50-5-207 (c) including stipulations of Section 37-1-203).

37-1-203 MCA. Conviction not a sole basis for denial. Criminal convictions shall not operate as an automatic bar to being licensed to enter any occupation in the state of Montana. No licensing authority shall refuse to license a person solely on the basis of a previous criminal conviction; provided, however, where a license applicant has been convicted of a criminal offense and such criminal offense relates to the public health, welfare, and safety as it applies to the occupation for which the license is sought, the licensing agency may, after investigation, find that the applicant so convicted has not been sufficiently rehabilitated as to warrant the public trust and deny the issuance of a license.

☐ The applicant has the financial ability to operate the facility in accordance with law or rules or standards adopted by the Licensure Department (Section 50-5-207 (d)).

Application for license for an Outpatient Facility is hereby submitted under the provision of Section 50-5-101 through 50-5-208. (See attached)

SIGNED _____ **DATE** _____

TITLE _____

ADDRESS: _____ **CITY** _____ **STATE/ZIP** _____

Enclose a check, money order or draft made payable to the *Department of Public Health & Human Services* to cover the license fee. The fee is determined as follows:

(a) facilities with 20 or less = \$20.00

(b) facilities with 21 beds or more = \$1.00 per bed.

This fee will be deposited in the State Treasury and is non-refundable.

For additional information see the following Web Pages:

<http://www.dphhs.mt.gov>

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<http://www.dphhs.mt.gov/gad/healthcarefacilities.shtml>